able costs, provided the organization's function and purpose are directly related to providing resident care.

4.26 **Post-Retirement Benefits**

Certain benefits which may be available to retired personnel are not required to be accrued in accordance with Generally Accepted Accounting Principles. If it should be determined by the FASB or other authoritative body that such post retirement benefits must be accrued, the Division will not allow costs of such benefits that exceed actual cost paid.

4.27 **Public Relations**

Costs incurred for services, activities and events that are determined by the Division to be for public relations purposes will not be allowed.

4.28 **Related Party**

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

4.29 **Revenues**

Where a facility reports operating and non-operating revenues related to goods or services, the costs to which the revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than such costs, the deduction shall be equal to such costs.

4.30 **Travel/Entertainment Costs**

Only reasonable and necessary costs of meals, lodging, transportation and incidentals incurred for purposes related to resident care will be allowed. All costs determined to be for the pleasure and convenience of the provider or providers' representatives will not be allowed.

4.31 **Transportation Costs**

(a) Costs of transportation incurred, other than ambulance services covered pursuant to the *Vermont Welfare Assistance Manual,* that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

(b) Transportation costs related to residents receiving kidney dialysis shall be reported in the Ancillary cost category, pursuant to subsection 6.7(a)(5).

4.32 **Services Directly Billable**

Allowable costs shall not include the cost of services to individual residents which are ordinarily billable directly to Medicaid irrespective of whether such costs are payable by Medicaid.

5 REIMBURSEMENT STANDARDS

5.1 **Prospective Case-Mix Reimbursement System**

(a) In general, these rules set out incentives to control costs and Medicaid outlays, while promoting access to services and quality of care.

(b) Case-mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection;

(2) a means to classify residents into groups which are similar in costs, known as VT 1992 RUGS-III (44 group version) and

(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score.

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in Subsection 9.2.

5.2 **Retroactive Adjustments to Prospective Rates**

(a) In general, a final rate may not be adjusted retroactively.

(b) The Division may retroactively revise a final rate under the following conditions:

(1) as an adjustment pursuant to Sections 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to Subsection 15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to Subsections 5.10, 8.3, 8.3, and 10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 3.5;

(6) in those cases where a rate includes payment for Ancillary services and the provider subsequently arranges for another Medicaid provider to provide and bill directly for these services;

(7) recovery of overpayments, or other adjustments as required by law or duly promulgated regulation;

(8) when a special rate is revised pursuant to subsection 14.1(e)(2) or

(9) when revisions of final rates are necessary to pass the upper limits test in 42 C.F.R. §447.272.

5.3 **Lower of Rate or Charges**

(a) At no time shall a facility's Medicaid per diem rate exceed the provider's average customary charges to the general public for nursing facility services in semi-private rooms at the beginning of the calendar quarter. In this subsection, "charges" shall mean the amount actually required to be paid by or on behalf of a resident (other than by Medicaid, Medicare Part A or the Department of Veterans Affairs) and shall take into account any discounts or contractual allowances.

(b) It is the duty of the provider to notify the Division within 10 days of any change in its charges.

(c) Rates limited pursuant to paragraph (a) shall be revised to reflect changes in the provider's average customary charges to the general public effective on the latest of the following:

(1) the first day of the month in which the change to the provider's charges is made if the changes is effective on the first day of the month,

(2) the first day of the month after the effective date of the change to the provider's charges if the change to the provider's charges is not effective on the first day of the month, or

(3) the first day of the month following the receipt by the Division of notification of the change pursuant to paragraph (b).

5.4 **Interim Rates**

(a) The Division may set interim rates for any or all facilities. The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to any provision of these rules or 33 V.S.A. §909.

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

5.5 **Upper Payment Limits**

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272, using Medicare principles of reimbursement.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

5.6 **Base Year**

(a) A Base Year shall be a calendar year, January through December.

(b) The Director shall determine the frequency of rebasing and shall select the Base Year. However, rebasing for nursing care costs shall occur no less frequently than once every three years and for other costs no less frequently than once every four years, unless the Secretary, on the advice of the Director, certifies to the General Assembly that rebasing is unnecessary or a modification of this schedule is authorized by statute.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year or the Division may use the facility's fiscal year cost report adjusted by the inflation factors in subsection 5.8 to the Base Year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

5.7 **Occupancy Level**

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used, pursuant to section 7, in determining the per diem rate for all categories except the Nursing Care category.

(c) The 90 percent minimum occupancy provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10.

5.8 **Inflation Factors**

The Director shall determine the specific publication of each index used in the calculation of inflation factors. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example, if an average cost in the Nursing Care Cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the Health-Care Cost Review NHMB, and the employee benefits portion of the NHMB, respectively.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses five price indexes to account for estimated economic trends with respect to five subcomponents of

Resident Care costs: wages and salaries, employee benefits, food, utilities and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Review NHMB, the employee benefits portion of the NHMB, the food portion of the NHMB, the utilities portion of the NHMB and the NECPI-U (all items), respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Review NHMB, the employee benefits portion of the NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Review NHMB, and the employee benefits portion of the NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

5.9 **Costs for New Facilities**

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to 90 percent occupancy of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in Sections 4 and 7 shall apply.

(b) The costs reported in the budget cost report shall not exceed reasonable budget projections (adjusted for inflation and changes in interest rates as necessary) submitted in connection with the Certificate of Need.

(c) Property and related costs included in the rate shall be consistent with the property and related costs in the approved Certificate of Need.

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to subsection 3.2 for its first full fiscal year of operation.

5.10 **Costs for Terminating Facilities**

(a) When a nursing facility plans to discontinue all or part of its operation, the Division may adjust its rate so as to ensure the protection of the residents of the facility.

(b) A facility applying for an adjustment to its rate pursuant to this subsection must have a transfer plan approved by the Department of Aging and Disabilities, a copy of which shall be supplied to the Division.

(c) An application under this subsection shall be made on a form prescribed by the Director and shall be accompanied by a financial plan demonstrating how the provider will meet its obligations set out in the approved transfer plan.

(d) In approving such an application the Division may waive the minimum occupancy requirements in Subsection 5.7, the limitations on costs in Section 7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this subsection shall remain in effect for a period not to exceed six months.

6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

6.1 General

In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. The Base Year costs shall be grouped into the following cost categories:

6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual costs of licensed personnel providing direct resident care, which are required to meet federal and state laws as follows:

(1) registered nurses,
(2) licensed practical nurses,
(3) certified or licensed nurse aides, including wages related to initial and ongoing nurse aide training as required by OBRA,
(4) contract nursing,
(5) fringe benefits, including child day care.

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

(a) food, vitamins and food supplements,
(b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
(c) activities personnel, including recreational therapy and direct activity supplies,
(d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
(e) counseling personnel, chaplains, art therapists and volunteer stipends,
(f) social service worker
(g) employee physicals,
(h) wages for paid feeding/dining assistants only for those hours that they are actually engaged in assisting residents with eating,
(i)
fringe benefits, including child day care,

(j) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

6.4 Indirect Costs

(a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from a facility's cost report or the cost report of an affiliated hospital or institution.

(1) fiscal services,
(2) administrative services and professional fees,
(3) plant operation and maintenance
(4) grounds,
(5) security,
(6) laundry and linen,
(7) housekeeping,
(8) medical records,
(9) cafeteria,
(10) seminars, conferences and other in-service training (except tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED which shall be treated as fringe benefits),
(11) dietary excluding food,
(12) motor vehicle,
(13) clerical, including ward clerks,
(14) transportation (excluding depreciation),
(15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
(16) office supplies/telephone,
(17) conventions and meetings,
(18) EDP bookkeeping/payroll,

(19) fringe benefits including child day care.

(b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure.

6.5 **Director of Nursing**

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

6.6 **Property and Related**

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

(b) For a change in services, facility, or a new health care project with projected property and related costs of $250,000 or more, providers shall give written notice to the Division no less than 60 days before the commencement of the project. Such notice shall include a detailed description of the project and detailed estimates of the costs.

6.7 **Ancillaries**

(a) The following are ancillary costs:

(1) All physical, speech, occupational , and respiratory therapy services and therapy supplies (excluding oxygen) shall be considered ancillaries. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless the services are provided:

(i) pursuant to a physician's order,

(ii) by a licensed therapist or other State certified or registered therapy assistant, or other therapy aides, and

(iii) the facility has a denial of payment by the Medicare program for the services provided.

(iv) The provider records charges by payor class for all units of these services.

(2) Medical supplies, whether or not the provider customarily records charges.

(i) Medical supplies shall include, but are not limited to: intravenous fluids or solutions, oxygen, disposable catheters, incontinent supplies, catheters, colostomy bags, drainage equipment, trays and tubing.

(ii) Medical supplies shall not include rented or purchased equipment.

(3) Non-legend drugs. All drug costs will be disallowed for providers commingling the costs of legend and non-legend drugs.

(4) Incontinent Supplies and Personal Care Items: including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc., and

(5) Dialysis Transportation. The costs of transportation for Medicaid residents receiving kidney dialysis shall be included in the ancillary cost category. Allowable costs may include contract or other costs, but shall not include employee salaries or wages or cost associated with the use of provider-owned vehicles.

(6) Overhead costs related to ancillary services and supplies are included in ancillary costs.

(b) Irrespective of any charging or accounting practices in effect during the current cost reporting period, no costs shall be allowed in the Ancillary cost category, if such costs were included in the Resident Care or another cost category during the Base Year.

7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care and Ancillary cost category, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

7.2 Nursing Care Component

(a) Case-Mix Weights.

(1) There are 44 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Class No.	RUG	Case-Mix Weight	Description
1	RVC	2.0158	Rehabilitation Very High Intensity C
2	RVB	1.4803	Rehabilitation Very High Intensity B
3	RVA	1.3129	Rehabilitation Very High Intensity A
4	RHD	1.8738	Rehabilitation High Intensity D
5	RHC	1.4959	Rehabilitation High Intensity C
6	RHB	1.3746	Rehabilitation High Intensity B
7	RHA	1.2441	Rehabilitation High Intensity A
8	RMC	1.7503	Rehabilitation Medium Intensity C
9	RMB	1.3120	Rehabilitation Medium Intensity B
10	RMA	1.2336	Rehabilitation Medium Intensity A
11	RLB	1.2371	Rehabilitation Low Intensity B
12	RLA	1.1028	Rehabilitation Low Intensity A
13	SE3	3.7496	Extensive Services 3
14	SE2	2.2493	Extensive Services 2
15	SE1	1.5423	Extensive Services 1
16	SSC	1.4054	Special Care C
17	SSB	1.2600	Special Care B
18	SSA	1.1740	Special Care A
19	CD2	1.2334	Clinically Complex D with Depression
20	CD1	1.2002	Clinically Complex D w/o Depression
21	CC2	1.0846	Clinically Complex C with Depression
22	CC1	1.0246	Clinically Complex C w/o Depression
23	CB2	1.0286	Clinically Complex B with Depression
24	CB1	0.9094	Clinically Complex B w/o Depression
25	CA2	0.8834	Clinically Complex A with Depression
26	CA1	0.7337	Clinically Complex A w/o Depression
27	IB2	0.9275	Impaired Cognition B- 2 NSG Rehab
28	IB1	0.8341	Impaired Cognition B
29	IA2	0.7274	Impaired Cognition A- 2 NSG Rehab
30	IA1	0.6283	Impaired Cognition A
31	BB2	0.9283	Challenging Behavior B - 2 NSG Rehab
32	BB1	0.8195	Challenging Behavior B
33	BA2	0.6560	Challenging Behavior A- 2 NSG Rehab
34	BA1	0.5590	Challenging Behavior A
35	PE2	1.0347	Reduced Physical Functioning E 2
36	PE1	0.9925	Reduced Physical Functioning E 1
37	PD2	0.9723	Reduced Physical Functioning D 2
38	PD1	0.9122	Reduced Physical Functioning D 1
39	PC2	0.8327	Reduced Physical Functioning C 2
40	PC1	0.8156	Reduced Physical Functioning C 1
41	PB2	0.7316	Reduced Physical Functioning B 2
42	PB1	0.6536	Reduced Physical Functioning B 1
43	PA2	0.6279	Reduced Physical Functioning A 2
44	PA1	0.5149	Reduced Physical Functioning A 1

(2) For residents certified by the Division of Licensing and Protection to have Atypically Severe Challenging Behaviors, the case-mix weight shall be 1.843.

(b) Average case-mix score

The Department of Aging and Disabilities' Division of Licensing and Protection shall compute each facility's average case-mix score .

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point.

Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Limits on Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(2) The limit on per diem Nursing Care costs per case-mix point shall be the median plus 15 percent.

(3) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (2) or the facility's Nursing Care cost per case-mix point.

7.3 **Resident Care Base Year Rate**

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs.

7.4 **Indirect Base Year Rate**

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be set as follows:

(1) For special hospital-based nursing facilities, the limit shall be 137 percent of the median.

(2) For all other privately-owned nursing facilities, the limit shall be the median.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs.

7.5 **Director of Nursing Base Year Rate**

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 **Ancillary Services Rate**

(a) The Ancillary per diem rate shall be computed as follows:

(1) Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be the sum of the following per diem costs calculated as follows:

(i) Costs for therapy services per diem shall be calculated by dividing allowable Medicaid costs by the number of related Medicaid resident days less Medicaid hold days.

(ii) Dialysis transportation costs per diem shall be calculated by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(iii) Costs for medical supplies, non-legend drugs, and incontinent supplies and personal care items per diem shall be calculated by dividing allowable costs, by total resident days less hold days.

(b) Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 **Property and Related Per Diem**

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.8 **Limits Final**

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d). These limits will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors or a change in law necessitating such a change.

8 ADJUSTMENTS TO RATES

8.1 **Change in Services**

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) a new health care project previously approved under the provisions of 18 V.S.A. §9434. Costs greater than those approved in the Certificate of Need (as adjusted for

inflation) will not be considered when calculating such an adjustment,

(b) a change in services, facility, or new health care project not covered under the provisions of 18 V.S.A. §9434, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

8.2 **Change in Law**

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

8.3 **Facilities in Receivership**

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred during the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

8.4 **Efficiency Measures**

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

8.5 **Interest Rates**

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this subsection for a period of up to two years.

8.6 **Emergencies and Unforeseeable Circumstances**

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

8.7 **Procedures and Requirements for Rate Adjustments**

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(c) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis

for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section may be continued as such, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9 Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

8.8 Limitation on Availability of Rate Adjustments

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rate for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The up-date is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

9.4 **State Nursing Facilities**

(a) Payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services.

(b) No less than 90 days before the beginning of the state fiscal year, a state nursing facility shall file with the Division in a form acceptable to the Director, a proposed budget for that fiscal year. The Division shall review this filing for reasonableness and shall determine an approved budget which shall be the basis for the facility's interim rates for that fiscal year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility's allowable costs. The Division may limit allowable costs to those in the approved budget.

(d) At no time shall the final rates paid to State nursing facilities exceed in aggregate the upper limits established in 42 C.F.R. §447.272.

9.5 **Quality Incentives**

Certain supplemental payments may be made to nursing facilities to be used for facility quality enhancements.

(a) Awards. Supplemental payments may be made to facilities that provide a superior quality of care in an efficient and effective manner. These payments will be based on:

(1) objective standards of quality, which may include resident satisfaction surveys, to be determined by the Department of Aging and Disabilities, and

(2) objective standards of cost efficiency determined by the Division.

(b) Innovative Pilot Projects. Supplemental payments may be made to facilities for all, or a portion, of the costs, approved by the Department of Aging and Disabilities, for creative and innovative pilot projects designed to improve and enhance residents' quality of life.

(1) In order to be eligible for supplemental payments under (b), the project must be suitable for replication in other facilities.

(2) Supplemental payments under (b) will not be available:

(i) to continue projects or programs already in place, or

(ii) to solve any issue of regulatory non-compliance.

(c) Supplemental Quality Incentive Payments.

(1) The supplemental payments may be made periodically from a quality incentive pool to certain nursing facilities whose operations meet the standards established pursuant to this subsection.

(2) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program, when implemented.

(3) Supplemental payments shall be expended by the provider to enhance the quality of care provided in the facility. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.